No. 93-510

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE FOR THE AMERICAN COUNCIL OF LIFE INSURANCE IN SUPPORT OF THE PETITION

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MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE FOR THE AMERICAN COUNCIL OF LIFE INSURANCE IN SUPPORT OF THE PETITION

The American Council of Life Insurance ("ACLI") hereby moves, pursuant to Rule 37.2 of the Rules of this Court, for leave to file the attached brief as amicus curiae. Consent to the filing of this brief has been obtained from counsel for the petitioners, Aetna Life Insurance Company and Aetna Health Management. Counsel for the respondent, Stuart Circle Hospital Corporation, has refused consent.

The ACLI is the largest life insurance trade association in the United States, representing the interests of 616 member life insurance companies. The ACLI's members currently hold 95 percent of the life insurance in force in

legal reserve life insurance companies in the United States. Most of its members also provide health insurance.

The insurance industry plays a critical role in providing welfare benefits to members of the nation's workforce through benefit plans governed by the Employee Retirement Income Security Act of 1974, *as amended*, 29 U.S.C. §§ 1001-1461 ("ERISA"). As of 1979, insurance companies—including many members of the ACLI—funded through group policies approximately 99 percent of the benefit plans in the United States that covered fewer than 100 participants. *See* "Employee Welfare Benefit Plans and Plan Sponsors in the Private Non-farm Sector in the United States, 1978-79," Health and Population Study Center, Battelle Human Affairs Research Centers, Vol. IV (1980), at 43-45. Approximately 92 percent of the plans in this country covering greater than 100 participants were also funded in this way. *Id.* Many members of the ACLI offer or administer preferred provider organizations ("PPOs") that provide significant cost savings to employee welfare benefit plans subject to ERISA.

Because of its nationwide constituency, the ACLI is peculiarly able to present to this Court the views of the life and health insurance industries concerning the issue presented in this case: whether ERISA preempts a state law that mandates that any health care providers "willing" to meet the terms of an insurer-offered or insurer-administered PPO used by an employee benefit plan to deliver health care services must be included in the PPO. Those views are particularly important where, as here, resolution of this case requires interpretation of ERISA's "insurance saving clause" and turns in part on the meaning of "regulating the business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. They are also important because, if the decision below stands, it will greatly increase the costs to employers of providing health care benefits to their employees and their dependents by, in effect, eliminating the PPO as an innovative and

extremely popular means of providing cost-efficient health care in states with "any willing provider" laws.

In other ERISA cases, the ACLI has submitted amicus briefs to this Court. *See, e.g., Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). For these reasons, the motion for leave to file the attached brief amicus curiae in support of the Petition should be granted.

Respectfully submitted,

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QUESTION PRESENTED

Whether a state law that mandates only the health care providers to be included in a preferred provider organization used by an employee benefit plan to deliver health care services, rather than restricts the services that such providers must provide participants in such plans, is preempted under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

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BRIEF AMICUS CURIAE FOR THE AMERICAN COUNCIL OF LIFE INSURANCE IN SUPPORT OF THE PETITION

This brief is filed on behalf of the American Council of Life Insurance ("ACLI"), as amicus curiae, in support of the petition for certiorari.[1]

INTEREST OF THE AMICUS

As explained in more detail in the accompanying Motion, the ACLI is the largest life insurance trade association in the United States, representing the interests of

[1] Consent from counsel for Aetna Life Insurance Company and Aetna Health Management has been filed with the Clerk of this Court. Because counsel for Stuart Circle Hospital Corporation refused to give consent, this brief is accompanied by a motion for leave to file this amicus brief.

616 member life insurance companies. The ACLI's members currently hold 95 percent of the life insurance in force in legal reserve life insurance companies in the United States. Its members also play a critical role in providing welfare benefits to members of the nation's workforce by insuring and or administering benefit plans governed by the Employee Retirement Income Security Act of 1974, *as amended*, 29 U.S.C. §§ 1001-1461 ("ERISA").

The legal and practical consequences of the Fourth Circuit's decision below are matters of grave concern to the members of the ACLI. That decision—that ERISA does not preempt a state law that mandates the inclusion of "any willing provider" in a preferred provider organization ("PPO") offered or administered by an insurance company—greatly increases the costs to employers of providing health care benefits to their employees and their dependents. In effect, it threatens to eliminate an innovative and extremely popular means of providing cost-efficient health care. Because of this impact, the ACLI seeks to file this brief to provide the Court with the unique perspective of its broad-based constituency on this important federal question.

STATUTES INVOLVED

1. Section 514(a) of ERISA provides, in pertinent part, that:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a).

2. Section 514(b) of ERISA provides, in pertinent part, that:

> (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> [2](B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title . . . nor any trust established under such plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts . . . .

29 U.S.C. § 1144(b).

3. Section 514(c) of ERISA provides, in pertinent part, that:

> (1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State . . . .
>
> (2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

29 U.S.C. § 1144(c).

4. Section 2 of the McCarran-Ferguson Act provides, in pertinent part, that:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by a State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the

> business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

15 U.S.C. § 1012.

5. Section 38.2-3407 of the Virginia Code provides, in relevant part, that:

> A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.
>
> B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

Virginia Code § 38.2-3407.

STATEMENT

Like a number of other states, Virginia has enacted, as part of its state insurance code, what is commonly referred to as an "any willing provider" statute. This "any willing provider" law requires a PPO, offered or administered by an insurer, to include in its organization any health care provider willing to meet the terms and conditions of the organization. As enacted, the mandate embodied in Virginia Code § 38.2-3407 is not limited to situations where an insurance company insures, through the issuance of insurance to the subscriber plan, the payment of the services offered by the PPO. It also applies when the insurance company does no more than administer a PPO for the benefit of self-insured employee benefit plans.

Aetna Life Insurance Company ("Aetna") both administers and insures employee benefit plans providing benefits in Virginia. Pet. 4. Aetna Health Management ("Aetna Health") maintains and manages the PPO that Aetna established to serve the Richmond, Virginia area. *Id.* Both insured and self-insured employee benefit plans subscribe to Aetna's Richmond PPO; for those plans that are self-insured, Aetna merely provides administrative services. *Id.*

Stuart Circle Hospital Corporation ("Stuart Circle") owns and operates a hospital in Richmond. Pet. 4. In structuring and establishing its Richmond PPO, Aetna did not include Stuart Circle as a provider. *Id.* Stuart Circle responded by suing Aetna and Aetna Health in Virginia state court, alleging a violation of Virginia Code § 38.2-3407. *Id.* Aetna and Aetna Health removed the case, on diversity grounds, to the United States District Court for the Eastern District of Virginia. *Id.*

The Proceedings Below

The district court granted Aetna's motion for summary judgment, holding that ERISA preempted Section 38.2-

3407 of the Virginia Code. Pet. App. 14a-32a. The court concluded that the Virginia law "relates to" employee benefit plans, as contemplated in the preemption provisions of ERISA § 514(a) (*id.* at 18a-24a), and is not "saved" from preemption as a law that "regulate[s] insurance", as contemplated in ERISA § 514(b)(2)(A). *Id.* at 24a-32a. In holding that the Virginia law is not "saved" from preemption, the district court relied on the criteria used in determining whether a state law "regulates insurance" under the McCarran-Ferguson Act. *Id.*

Specifically, the district court relied on this Court's decision in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), that a service arrangement between an insurance company and a group of pharmacies, which restricted the pharmacies available to the insured participants of employee benefit plans, was not an arrangement that involved the "business of insurance." By analogy, the district court held that state-mandated inclusions of willing providers into PPOs do not involve the type of transfer of risk between an insurer and an insured that is essential to the "business of insurance." Pet. App. 27a-28a. Rather, according to the court, a PPO is merely a contractual relationship among health care providers permitting an insurance company, through its management or administration of the PPO, to aid in providing cost-efficient health care to the participants of subscribing employee benefit plans. *Id.*

On appeal, the Fourth Circuit reversed, holding that the Virginia statute is not preempted because that law regulates the "business of insurance" as contemplated in ERISA's "savings" clause. Pet. App. 3a-13a. The Fourth Circuit based its holding on two grounds. First, it concluded that the Virginia "any willing provider" law regulates the "business of insurance" because it indirectly regulates the relationship between the insurer and the insured, as well as the type of policy that may be issued. *Id.* at 9a. Second, it concluded that the Virginia law meets all three prongs of the test for the "business of

insurance" traditionally used in the context of the McCarran-Ferguson Act. *Id.* at 9a-11a. In the court's view, the law (1) transferred the risk that the service will not be provided by the health provider of the policyholder's choice, (2) affected an integral part of the policy relationship between the insured and the insurer, and (3) applied solely to entities within the insurance industry. *Id.*

REASONS FOR GRANTING THE WRIT

I. THE COURT BELOW DECIDED AN IMPORTANT ISSUE OF FEDERAL LAW IN A MANNER INCONSISTENT WITH THE DECISIONS OF THIS COURT.

Section 514(b)(2)(A) of ERISA saves from preemption any state law that "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985), this Court stated that the "business of insurance" for purposes of ERISA's "savings" clause is coextensive with those activities that are reserved to state regulation under the McCarran-Ferguson Act. Thus, this Court has applied the criteria for evaluating the "business of insurance" under the McCarran-Ferguson Act in deciding the applicability of ERISA's "savings" clause to state laws. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

In so doing, this Court has used the three-prong test articulated in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982), and *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), to define the scope of the phrase "any law of any State which regulates insurance" in ERISA's "savings" clause. That test, applied to ERISA in *Metropolitan Life*, means that a state law will be deemed to "regulate insurance" if it (1) effects the transfer or spreading of risk between the insurer and the policyholder; (2) is limited to entities within the insurance industry; and (3) affects an integral part of the insured and insurer relationship. *Pireno*, 458

U.S. at 129; *Royal Drug*, 440 U.S. at 214-224; *Metropolitan Life*, 471 U.S. at 743.

By holding that the Virginia "any willing provider" law is a law regulating the "business of insurance" under this test—thus saving it from ERISA's broad preemptive reach—the Fourth Circuit both misconstrued and misapplied the well-established three-prong test of *Pireno* and *Royal Drug*. In the process, it has threatened widespread disruption of a widely-accepted method of providing cost-efficient health care—at a time when health care costs are spiraling—that only this Court can promptly avert.[2]

A. The Virginia Law Does Not Effectuate The Transfer Of Risk. The decision below that Virginia's "any willing provider" law effectuates the transfer of risk plainly misapplies this Court's well-settled insurance law principles: the Virginia law does not involve the true "underwriting" of risks—"the one earmark of insurance" (*SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 73 (1959))—much less the transfer of risk from an insured to the insurer that defines the contract of insurance.

Insurance companies that offer or administer PPOs are not engaged in the "underwriting" of insurance or the spreading of risk through a contract with one or more insured individuals or groups. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. at 211 ("The primary elements of an insurance contract are the spreading

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[2] In *United States Dept. of Treasury v. Fabe*, a non-ERISA case, this Court recently reiterated the validity of the three-prong test of *Pireno* and *Royal Drug* in determining what constitutes the "business of insurance" for purposes of the McCarran-Ferguson Act. 113 S.Ct. 2202 (1993). Moreover, most circuits have expressly adopted the three-prong test in determining the scope of ERISA's savings clause. *See, e.g., Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449, 1453 (5th Cir. 1991); *DeBruyne v. Equitable Life*, 920 F.2d 457, 469 (7th Cir. 1990); *Howard v. Gleason Corp.*, 901 F.2d 1154, 1158 (2d Cir. 1990); *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467, 1468 (11th Cir. 1988); *The Insurance Board Under the Social Ins. Plan of Bethlehem Steel Corp.*, 819 F.2d 408, 411 (3d Cir. 1987).

and underwriting of a policyholder's risk. 'It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it' "). Rather, such insurance companies are merely providing a service to employers sponsoring employee benefit plans by aiding those sponsors in implementing their particular health plans in the most cost-efficient manner.

The absence of a risk transfer, in the insurance sense, is clearly evident from the basic structure of a PPO. A PPO is nothing more than a mechanism for an employer to provide health care benefits to its employees, through an employee welfare benefit plan, at a reduced cost. The creator of a PPO enters into contracts with a limited number of health care providers, *i.e.*, "preferred providers," for the purpose of providing health care services to employee benefit plans. Cost savings result from the chosen health care providers' willingness to provide their services at substantial discounts due to various reasons, including the assured increase in patient volume that the PPO network of subscribers can guarantee.

Generally, this increase in patient volume is achieved through financial incentives given to participating plan participants. For example, an employee benefit plan that subscribes to the PPO may offer to pay participants a greater percentage of any cost of treatment rendered to them by preferred providers. The resulting increase in patient volume, in turn, yields a lower per patient cost to the preferred providers by spreading the fixed cost of the PPO. This enables the providers to lower the charges per incidence of service.

Thus, a PPO is merely a contractual relationship between the PPO creator, or administrator, and the various preferred health care providers. The PPO contract does not specify what health care services will be covered by any particular subscribing employee benefit plan; it does not, by its terms, provide insurance coverage to any sub-

scribing plan or require any plan to be insured in order to subscribe. Indeed, in many instances, the PPO creator or administrator may not even be an insurance company. Thus, whether a subscribing plan is fully-insured, partially-insured, or self-insured is a separate contractual matter totally outside the PPO contract. The PPO contract does nothing more than specify the discounted fees for which the various preferred providers within its network will provide their services to subscribers.

To the extent that providing services through a PPO network has a cost impact, this impact redounds to the plan and its participants—not to the insurer—in a manner that would constitute the "underwriting" of risk. For example, an insurer/administrator of a PPO that is also providing the insurance coverage for a subscriber plan can easily cap its costs based on a predetermined benefit-by-benefit payment schedule. Therefore, to the extent that more costly providers are added to the PPO network, the insurer *qua* insurer would need to pay no more than the scheduled amount, while either the plan sponsor or the participant would pay the monetary difference for the particular provision of service. Thus, in this instance, insofar as any shifting of cost occurs, it would consist of the mere shifting of cost for providing a defined list of services between the plan and its participants and the PPO itself. Such a risk shifting would, if anything, indicate that insurer status should apply either directly or indirectly to the plan. Clearly, however, the "deemer" clause would preclude any attempt to apply state insurance law directly to the plan or its participants or sponsor.[3]

Even where the employee benefit plan is fully insured through an insurance contract that specifically limits pay-

[3] Section 514(b)(2)(B) of ERISA is known as the "deemer" clause because it states, in effect, that no employee benefit plan may be deemed to be an insurance company or other insurer for purposes of any law of any state purporting to regulate insurance companies or contracts.

ments of benefits to services rendered by members of a particular PPO, that contractual restriction does not result in an underwriting of risk in the insurance sense. This is due to the fact that such a policy does not in any way restrict the type of illness or injury covered, *i.e.*, the type of benefit provided. Rather, such a provision restricts only *who* will provide the services. Such a restriction does not affect the risk that any individual participant will or will not be reimbursed for the treatment of any particular illness or injury. And it is this risk—that of being reimbursed for the treatment of any particular illness or injury—that is the generally-accepted relevant risk for purposes of determining insurance status. *See, e.g., United States Dept. of Treasury v. Fabe*, 113 U.S. 2202, 2209 (1993); *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981).

B. The Law Affects Entities Other Than Insurance Companies. The second prong of the three-prong test for determining whether a particular law regulates an activity involving the "business of insurance" involves determining whether the law applies *solely* to entities in the insurance industry. There is no legal or practical reason why the business of composing PPO networks is, or indeed should be, limited to insurance companies. In fact, many PPOs are created and administered by groups of medical service providers themselves—without any involvement of an insurance company. In addition, many benefit consulting groups structure such networks of health care service providers for their plan sponsor clients. In neither of these two fact patterns does the entity creating the PPO network assume any type of risk relating to benefits being provided to the subscriber plans. Therefore, it is plain that the function of creating or administering a PPO network, in and of itself, has nothing to do with an assumption of risk. Because that function is not limited to entities in the insurance industry, the activity that the Virginia law attempts to regulate fails to meet the second

prong of the *Pireno* and *Royal Drug* test for the type of activity that may be deemed the "business of insurance."

In reality, the creation or selection of a PPO is nothing more than a service to a plan sponsor or the plan and, as such, is a function separate and distinct from the provision of insurance. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). The facts of this case make that point clear: in many instances, Aetna did not provide insurance coverage to the subscribing plans, but merely provided administrative services relating to their subscriptions to the PPO.

Moreover, if the participant population of a plan sponsor were large enough, any such sponsor could command the attention of significant numbers of health care providers and thus create its own PPO network through its own selection process. In such a case, there would be no doubt that the "deemer" clause of ERISA § 514 would preclude the characterization of such a plan as an insurer and, hence, the application of any state insurance laws to such a plan. *See Metropolitan Life, supra.* Clearly, the hiring of an insurance company by the plan sponsor, either directly or indirectly, to create or provide a PPO network should not change the legal analysis that the "deemer" clause protects this activity. Indeed, such a service provider, whether an insurance company or another entity, is nothing more than an extension of the plan and its sponsor and, as such, shares in the "deemer" clause protection given the plan.

If Virginia's law is allowed to stand, it will have the adverse impact of denying small plans the advantages of the mega-plans. Unlike large plans, small plans and their sponsors do not have the economic clout or the numbers of potential patients necessary to attract and form independently cost-efficient PPO networks. Denying small plans the aid of insurance companies in the formation of cost-efficient PPO networks has the effect of denying them the easiest and least costly means of participating

in a PPO network. That, in turn, clearly has a direct impact on the design, operation and economics of those small plans.

C. The Law Does Not Affect The Relationship Between The Insurer and The Insured. Because the relationship between the entity that creates or administers a PPO network and any particular subscriber plan is purely and simply one of a service provider to such plan—and not one in which any type of risk is shifted—the activity that Virginia's "any willing provider" law attempts to regulate is not an activity that affects the relationship between an insurer and an insured. The activity being regulated by Virginia law is an activity that any entity, including the plan or its sponsor, could perform and involves no shifting of risk necessary to an insurance relationship. Although the Virginia law is strictly limited in application to insurance companies engaged in offering or administering PPO networks, it does not so regulate any insurer in its capacity as an insurer. Hence, the Virginia "any willing provider" law does not affect the relationship between an insurer and an insured, and thereby fails to meet the third and final prong of the *Pireno* and *Royal Drug* test.

The Fourth Circuit's contrary conclusion warrants this Court's review. That decision is inconsistent with this Court's established principles of ERISA preemption. *See Metropolitan Life*, 471 U.S. at 740. And it is irreconcilable with basic notions of risk in the insurance context. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. at 211-12.

II. THE DECISION BELOW WILL CREATE A SIGNIFICANT DISRUPTION IN THE EMPLOYEE BENEFIT COMMUNITY AND THREATENS TO ELIMINATE AN IMPORTANT MEANS FOR REDUCING THE NATION'S HEALTH CARE COSTS.

If the Fourth Circuit's decision is allowed to stand, an important weapon in the fight to control and, indeed, reduce this nation's health care costs will be eroded. This

is evidenced by the fact that, as of 1992, nearly 40 percent of all employers in the United States offered their employees some form of PPO, and nearly 58 million employees and dependents accepted these offers by participating in PPOs. American Association of Preferred Provider Organizations, "PPO Growth" (1993). The application of Virginia's "any willing provider" law will result in an increase in administrative costs while decreasing claims savings. Moreover, and more importantly, depending on the number of providers using the law to gain admittance to any particular PPO, the law will actually devalue the PPO as a cost-saving mechanism by eliminating its ability to provide any marginal savings as compared to other non-PPO providers. Report to Health Insurance Association of America: Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices, at 1-5 (Wyatt Co. 1991).

Cost efficiency is a legally permissible goal for plan sponsors. It should not be impermissible for plan sponsors to hire independent experts to aid them in their selection of plan service providers. Indeed, to the extent that any particular employee welfare benefit plan receives monies from plan participants for the purpose of defraying the costs of its offered benefits or the premiums supporting the insurance coverage for such benefits, the plan's fiduciaries have a duty under ERISA's fiduciary responsibility provisions to expend those assets as prudently as possible. The Virginia law would impede plan fiduciaries from fulfilling this responsibility and obligation to the best of their ability by eliminating a source of cost-efficient medical services. This is particularly true for smaller employers that do not have the economic power to negotiate successfully with individual health care providers to create their own PPO networks.

Not only do such results have a negative impact on the nation's health care costs, they are also entirely at odds with the words and intent of ERISA. Although ERISA

does not provide specific substantive design requirements for welfare plans, the resulting "regulatory void" merely evidences Congressional intent to leave those subjects to the discretion of plan sponsors. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981); *Standard Oil of Calif. v. Agsalud*, 442 F. Supp. 695, 705 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981). Lack of specific ERISA regulation does not give states the authority to fill in the "regulatory void." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98-99 (1983). Indeed, if states like Virginia are permitted to interfere with sponsor discretion, plan sponsors will be required to conform to a patchwork of state-mandated requirements concerning the offering of a PPO network or to eliminate the PPO option altogether.[4]

It is just such a result that ERISA's preemption provisions were meant to avoid. As this Court stated in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987):

> A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits.

The Court explained in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 105 & n.25:

> ERISA's comprehensive preemption of state law was meant to minimize this sort of interference with the administration of employee benefit plans, . . . [so

[4] Currently, several States have various types of "willing provider" laws. A number of states have laws similar to Virginia, *e.g.*, Georgia (Ga. Code Ann. § 33-20-16 (1990)); Illinois (215 Ill. Comp. Stat. Ann. 5/370h (1993)); Indiana (Ind. Code Ann. § 27-8-11-3 (Burns 1992)); Louisiana (La. Rev. Stat. Ann. § 40:2202 (West 1992)); Utah (Utah Code Ann. § 31A-22-617 (1991)); and Wyoming (Wyo. Stat. § 26-22-503 (1977)). Some states have laws that apply only to certain types of providers or only to certain types of arrangements. *See, e.g.*, Nebraska (Neb. Rev. Stat. § 44-4112 (1988)) and Idaho (Idaho Code § 41-1844 (1991)) respectively.

> that employers would not have] to administer their plans differently in each State in which they have employees.[5]

Allowing the lower court decision to stand will create the type of patchwork regulation that is directly contrary to the maintenance of nationwide employee benefit plans and that Congress intended to preclude through federal preemption.

This case is of nationwide importance. Certiorari should be granted to eliminate the "patchwork" diversity that will result from the Fourth Circuit's decision below.

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[5] The legislative history of ERISA is replete with support for this principle. *See, e.g.*, S. Rep. No. 127, 93d Cong., 1st Sess. 35 (1973), *reprinted in* 1 Legislative History of the Employee Retirement Income Security Act of 1974 (1976) ("Legislative History"), at 621 ("Except . . . in certain . . . enumerated circumstances, state law is preempted. Because of the interstate character of employee benefit plans, the Committee believes it essential to provide for a uniform source of law . . . ."); 120 Cong. Rec. 29,197 (1974) (Representative Dent) (broad federal preemption was designed to eliminate "the threat of conflicting and inconsistent State and local regulations"); 120 Cong. Rec. 29,933 (Senator Williams) ("the substantive and enforcement provisions . . . are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans"); 120 Cong. Rec. 29,942 (1974) (Senator Javits) ("the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit plans").

CONCLUSION

For the reasons set forth above and for the additional reasons advanced in the Petition, the writ of certiorari should be granted.

Respectfully submitted,

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